DOCUMENT RESUME

ED 460 441 EC 306 520

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TITLE	An Overview of DNR Orders: Considerations for School Districts.
INSTITUTION	South Atlantic Regional Resource Center, Plantation, FL.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC.
PUB DATE	1996-01-00
NOTE	8p.; SARRC became the Southeast Regional Resource Center (SERRC), Montgomery, Alabama.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Elementary Secondary Education; *Legal Problems; *Legal Responsibility; *Policy Formation; School Districts; *School Policy; *School Responsibility; *Special Health Problems
IDENTIFIERS	*Do Not Resuscitate Orders

ABSTRACT

This paper provides an overview of legal responsibilities of school districts relating to "Do Not Resuscitate" (DNR) orders for children who are medically fragile. It addresses the incidence of school children who are medically fragile and differences in state laws that affect DNR orders. Attitudes that are preventing school districts from making sound decisions are explored and steps districts should take to comply with DNR orders are provided. These include: (1) gaining assurance that the parent, guardian, or physician making the request have the authority to do so; (2) ascertaining whether any district staff has reason to believe the parent or guardian making the request lack the authority to do so, have done so for ulterior motives, or are not motivated in the students' best interests; (3) reviewing the request or order to determine whether it can be reasonably understood and implemented by employees; (4) identifying and considering each step in the implementation process; (5) making sure all staff who might provide services to the student are alerted that a DNR order exists; and (6) documenting all arrangements in a letter with all parties acknowledging in writing that they understand and agree to the procedures that should be followed. (CR)

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An Overview of DNR Orders: Considerations for School Districts

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Why School Personnel Must Know About DNR Orders

One of the central objectives of IDEA is to assure that all children with disabilities are educated in the "least restrictive environment." Among these are students informally called "medically fragile." These are children who require medication, catheterization, tracheostomy, respiratory assistance or other medical procedures, and usually intermittent or constant monitoring. They may have deteriorating diseases, they may appear to be "fragile", or they may appear to be perfectly normal. For purposes of special education administration, they are usually identified as students with "other health impairments" or "multiple disabilities."

But what truly distinguishes them as "fragile" is that they live on a knife edge: If they do not receive their medication, the proper amount or on time, if required medical procedures are not properly administered, or if there is a failure in the maintenance of their medication or procedures, they may die. It is not uncommon for emergency resuscitation procedures to be administered in such circumstances. Since educational personnel may be the only persons present, they may be faced with decisions about administration of resuscitation, and resuscitation itself.

It is at this point that questions concerning resuscitation, or not to resuscitate, arise. The acronym "DNR" (Do Not Resuscitate) has become familiar to most of us through television medical dramas. But the fact is that at least some of the medically fragile children now being served in schools may be subject to, or are candidates for, DNR orders. Nonetheless, very few education agencies have considered the practical problems or legal questions that may arise concerning these students. This article is intended to provide some guidance in this area. Preliminarily, however, a few cautionary words are in order.

First, there appear to be no court decisions dealing with the obligation of educational institutions or personnel to honor or ignore instructions concerning DNR orders. For this reason, all suggestions and advice offered herein should be considered as hypothetical, formulated in light of best current existing practices but conjectural nonetheless. The reason for the lack of case law probably reflects that DNR decisions are being made within the family, based upon competent medical advice and in consultation with religious advisers.

Second, problems concerning resuscitation are distinct from an education agency's obligation to serve medically fragile children. However uncertain may be the former, there can be no doubt about the latter. There is a clear, and for the most part unequivocal, record of decisions holding that children with complex medical needs are entitled to be educated within the public school system. The law does state that schools are not required to provide "medical" services, but even if this limitation is gradually being eroded, it has nothing to do with questions concerning DNR orders.

Third, this brief article is an overview of Federal requirements in an area that is primarily governed by state law. Many of the procedures required for medically fragile children are governed not by education statutes, but laws regulating nursing, medicine, or some other related field. The reader's first obligation is to consult an experienced attorney in his or her state and determine the relevant state statutes and regulations.

How many children may be subject to DNR orders?

Medically fragile students may have conditions that include ventilator dependence, tracheostomy dependence, oxygen dependence, nutritional supplement dependence, congestive heart problems, need for long-term care, need for high-technology care, apnea monitoring, or kidney dialysis. These students are similar in their needs for extreme medical care, usually including intervention while they are in school. However, each medical condition presents its own unique set of characteristics. Thus, there are no reliable figures on the number of students who are or may be subject to DNR orders. Among the eligibility categories established by IDEA, medically fragile students most likely would be found among those identified as having multiple disabilities or other health impairments.

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A presentation at the 1995 Annual Convention of the Council for Exceptional Children by Christine A. Schnieders and Robbie Ludy reported the results of a survey. It found the following:

47 school districts responded to the survey; they were split almost equally among urban, suburban and rural settings.

The mean student population of the respondents was 29,468; mean special education population was 3,360 (these may have included gifted); mean medically fragile population was 165. [The term "student population" was not defined for the participants.]

Of 47 districts that replied to the survey, 14 had a policy dealing with death of students, school personnel, and other similar matters; only 2 had clear DNR policy.

These two were opposed: one said it absolutely followed DNR orders from parents and physicians; the other said it kept students alive but would consider alternative life-sustaining measures with transportation to hospitals.

A report of a survey conducted by the Office of School Health of the University of Colorado Health Sciences Center, dated March 1995, also indicated that only a small number of school districts have formulated policies on DNR. The report was based on a 10% systematic random sample (1,677) of the nearly 16,000 school districts in the country, 482 (28.8%) of whom responded. This survey indicated that only 4.7% of school districts have a policy on DNR. Source: "A Closer Look", a Report of Selected Findings from the National Health Survey 1993-1994 (Denver 1995).

What is a DNR Order?

"DNR" stands for "do not resuscitate." It is a commonly used acronym for an order or directive that cardiopulmonary resuscitation not be used in the event of a cardiac or respiratory arrest. In the school setting, typically it would come from a parent, guardian, or student's physician.

A particular state's laws or regulations may define a DNR order differently or use a different term. These provisions may also address, among other things, in what settings DNR orders must be honored and the required response of personnel in those settings. While DNR orders traditionally have raised issues only in hospitals and nursing homes, absent state laws or regulations to the contrary, there is no reason to assume DNR orders should not be honored in other settings including schools.

Why Are DNR Orders Different?

DNR orders are different because they reverse the primary assumption regarding the provision of medical treatment. The primary assumption is that no treatment can be provided without a patient's consent. In the case of a minor or incompetent, that consent must be provided by a person authorized to act on behalf of the patient, usually a parent or guardian. It is the liability for treatment not authorized or consented to that is responsible for the mountain of forms patients must review and sign upon undergoing medical treatment.

For a person in cardiac arrest, the medical care -- procedures to prevent arrest or, in the event of arrest, resuscitation -- is provided automatically, unless the physicians have reason to believe that it should not be. Presumably this is because of the common assumption that most people would rather stay alive than die. But a DNR order is a direct contravention of this assumption. It is an explicit directive based upon a decision made by an authorized person (or persons) that extraordinary procedures shall not be used to continue the patient's life.

An exhaustive analysis of a person's right to refuse medical treatment is beyond the scope of this discussion. However, a brief review of some basic generally accepted principles is warranted. From a constitutional standpoint, a competent adult has the right to decide what medical treatment he or she will receive and to decline treatment even if needed to sustain life. This right may be overridden by the interest of the state or a third party, but ordinarily it will not be. When and how it is overridden is determined under state law.

As a general rule, parents also have the constitutional right to make educational decisions for their children. As a matter of common law, the same is true with regard to medical decisions in practically every state. Parents are the natural guardians of their children and have this right without any approval of a court authority unless their decisions jeopardize the health and well being of their children. While there are few reported cases regarding the authority of a parent to refuse life sustaining medical treatment for a child, generally they uphold the parent's right to refuse such treatment as long as the refusal is within the zone of reasonable medical choice, typically defined by the

child's attending physician.

Incompetent persons -- including children not mature enough to understand the consequences of a medical procedure, comatose adult persons, persons with diminished mental capacity -- also possess the right to refuse medical treatment, even if their condition prevents a conscious exercise of choice. Courts allow third parties to assert the incompetent's rights, usually a parent, other family member, or guardian. The question then becomes who shall make the decision and, next, how the decision shall be made.

In approximately four states, a court order is required before anyone can refuse medical treatment to an incompetent. In almost 40 states, a third party, typically a family member, is allowed to make the decision without court intervention. Remaining states have not yet decided the issue either statutorily or through case law. In these latter jurisdictions, one must assume that a court order is necessary before anyone can deny medical treatment to an incompetent person.

After it is determined who shall make the decision, the next question is how the decision shall be made. Basically, two standards are used: the "substituted judgment" and the "best interest" standards. The "substituted judgment" test requires the decision maker first to determine the incompetent person's probable desire as if the patient were competent (or actual preference if the patient has previously expressed it) and, then, render a decision in accordance with it. The "best interest" test requires the decision maker to base the decision on what he or she believes is in the best interest of the incompetent person. This latter standard is used in those situations where the probable desire of the patient cannot be ascertained, for example in the case of immature children or a patient who although once competent, never expressed an intent.

Regardless of the standard used, in any particular situation a countervailing state interest may outweigh a person's right to self-determination, even if the person is competent. Those state interests typically are: (1) the preservation of life; (2) the protection of the interest of innocent third parties, for example, children of the person; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession. Accordingly, at any time, some third party -- such as another family member, health care, or service provider -- could claim a state interest and seek court intervention directing that treatment be provided. The third party could also claim the DNR order should not be honored because to do so is not the person's desire or would be against the person's best interest.

Courts in most states have also held that a school's relationship to a pupil is one of *in loco parentis* -- the school, standing in place of the parents, is under a special duty to exercise reasonable care to protect the pupil from harm. The doctrine of *in loco parentis* is based upon the assumption that the school would do what the parent would do under the circumstances. Legal uncertainties and the possibility of tort liability have led schools to develop procedures for dealing with medical emergencies. In the absence of state law or predefined procedures, schools may appropriately ask properly trained school personnel to perform CPR on a child who has suffered cardiac arrest before or after emergency service personnel have been called. Some states, *e.g.*, Maryland, require the school health services professional and others (health services aide and at least one adult) in each school be certified in CPR.

However, the *in loco parentis* doctrine does not give school district staff the authority to act contraryto the parent's expressed wishes. In other words, the *in loco parentis* doctrine, together with the doctrine of informed consent, allows a school to provide emergency medical treatment to a student where the parent has provided no direction. But, where a parent has already refused to consent to emergency treatment, *e.g.*, CPR evidenced by a DNR order, in most states a school district is assuming a substantial risk if it does not honor the DNR order and substitutes its judgment for that of the parents. In the face of a DNR order, the district's duty is clear. Violating a DNR order in most states under these circumstances will subject the district and its employees to the risk of liability for battery and a variety of other torts including, but not limited to, wrongful life actions.

The second most important point to remember is this: it is imperative that before any district establishes a policy or procedure on DNR orders, or responds to any specific DNR order, it closely review state laws on the subject. Moreover, given that this area of the law is fast developing, the current law should be monitored on a continual basis. It is very doubtful any rulings that specifically address the issue in a school setting will be found. One recent exception is an opinion by the Maryland Attorney General. It directly addresses the question of whether a public school must accept and follow a DNR order from the parents of a terminally ill child. In a lengthy analysis, interpreting rights under the common law, the federal and state constitutions, and Maryland's state laws, the attorney general concluded that school officials must accept the DNR order and refrain from medical interventions that are not consistent with it. 79 Opinions of the Attorney General [Opinion No. 94-028] (May 13,1994).

What Attitudes Are Preventing Sound Decisions?

Abdicating Its Authority

Probably the most significant attitude problem faced by school districts, their counsel, or both is to allow various

considerations to serve as an excuse for avoiding or not complying with the law. For example, school districts may face the moral concerns of staff -- board members, administrators, or teachers, who understandably feel they are in education to help these kids, not "kill them"-- or "political" pressure from "right to life" groups or others. As a result, the district refuses to implement a DNR order where state law clearly places the decision in a family member without need for court intervention, and declines to initiate any court action to contest the order as against the best interests of the child. Such a response simply countermands the parent's presumptive authority and leaves the district open to potential litigation by the parents under IDEA or Sec. 504. In sum, if the district or its staff take no action to protect the child from implementation of the DNR order, it is merely paying lip service to the best interests of the child.

Placing School Personnel in Jeopardy

Most significantly, by refusing to honor the DNR order, the district has placed itself and its staff in an extremely difficult and unfair position both legally and practically. If district staff are aware of the district's position and a situation arises requiring CPR, they will be in a quandary as to what they should do. Some staff almost become members of a student's family and may be tempted to follow the desires of the parents despite the district's action. Others who follow the district's refusal to honor the DNR order may be subject to tort liability. To avoid these pitfalls, a district must take a position on DNR orders. It must ensure that its employees understand the decision in each case is one to be made by the district pursuant to its policy and not by an individual employee under the circumstances of the moment.

Misreading the case law

Some district legal counsel, due to the sparsity of decisions regarding children who are not competent, terminally ill, or in a vegetative state, contend the case law on the right to refuse treatment doesn't apply to students with disabilities. Some will contend that such decisions arise only in health care settings and do not apply to school settings. Given that the case law on the right to refuse treatment has constitutional underpinnings that are not dependent upon the reason the child is incompetent (including a possible variety of health related conditions), or the setting in which the right might be exercised -- for example, in a hospital, school, or someplace else -- attempts to draw such fine distinctions on such grounds from a legal standpoint would appear to be a very strained interpretation of the law to avoid addressing the real issue.

Misinterpreting the Required Standard

A DNR order does not require school personnel to decide on a daily basis whether CPR should be administered - unlike the decision a doctor would make in a hospital setting. Again, assuming as in the majority of states that the decision (absent third party intervention) is for the family to make, the decision has already been made and it is not for a doctor in the hospital setting or school personnel in the school setting to make medical interventions inconsistent with it.

Concluding that Denying CPR Violates FAPE

Sometimes district and their counsel contend that refusing to provide a service such as CPR to a student with disabilities constitutes a violation of IDEA by denying the student a free appropriate public education (FAPE) or discriminates against the student under either Sec. 504, the ADA, or both ("you wouldn't honor the DNR order if the student had no disabilities").

Interestingly, the U.S. Department of Education's Office of Civil Rights (OCR) is currently reviewing whether it should take a position concerning DNR orders and, if so, what it should be. But the contention that honoring the DNR request would violate any of these laws would seem to fail for two reasons. First, the right to refuse medical treatment is constitutionally based; Therefore, if implemented appropriately in accordance with state laws, no other law -- state or federal, including IDEA, Sec. 504, or the ADA -- would probably be allowed to limit or prohibit the exercise of the constitutional right.

Second, as noted above, while districts typically refuse parent requests for a particular services, and then have to face due process or other proceedings, they face the same consequences here where a district wants to provide a child a service (CPR), but the parents, on behalf of the child, refuse it.

Avoiding the Problem

There are some districts, even some organizations providing policy consultation services to districts, who take the position that a district should just refuse to honor any DNR order and instead offer the child services in the home setting. They reason that for this child, given the parent's desires, the home setting constitutes the least restrictive environment. Among other things, they contend that other students will suffer potential harm if the student is not resuscitated in their presence.

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Given the previous discussion of the law and the decisions on LRE generally, justifying a home placement on this basis would be very shaky to say the least. Moreover, the potential adverse impact on other students can, and should, be addressed as will be discussed below. Moreover, a district refusing to honor a DNR order might face a claim of discrimination on the basis that CPR for a particular student, given the particular condition, may in fact cause more harm than an alternative medical intervention or no intervention at all.

What Have the States Done?

Not all states have developed DNR procedures, but those that have, or are in the process of doing so, differ widely in their approach. This reflects the significant ethical and legal considerations in developing such policies.

Example: The Lewiston, Maine, School Board was forced to deal with these issues when Corey Brown's mother requested that her 12-year-old daughter not receive chest compressions if she went into cardiac arrest. After several reversals, the board issued a policy that teachers are not to follow a DNR order. They must develop an individually designed resuscitation plan (IRP) to be followed in case of emergency. The Office for Civil Rights stated that the IRP was not discriminatory. Factors considered were that (1) the IRP had been designed by multidisciplinary team including parent, physicians and appropriate school personnel; (2) the IRP was based on expert medical and other relevant information, and was appropriately documented; (3) a second medical opinion was required; and (4) the IRP was of limited duration, ensuring that it would be re-evaluated periodically.

Example: Maryland has issued a different policy interpretation. The Maryland Attorney General, as previously noted, recently advised that if the attending physician of a child has entered a DNR order on the authorization of the child's parents, school officials must act in accordance with the order.

Example: Connecticut, Oklahoma, and Washington State are developing state wide policies on DNR orders in the public schools. But the Washington State School Directors Association guidelines on the responsibility of school and staff in responding to medical emergencies advises that school staff should not agree to withhold treatment, regardless of personal belief or relationship with parents, and that the best practice is probably to not accept a DNR directive in the student's files.

Example: Executive Board members of the Association of the Severely Handicapped (TASH) have expressed concern about the implementation of DNR orders in the schools because of the potential discrimination towards people with disabilities.

What Should a District Do About DNR Orders Generally?

Aside from responding to DNR orders, every district should have established policies or procedures on the identification, evaluation, and planning of any school health services required by a student. Minimally, information must be obtained about the student's health problems, the interventions necessary to address them, and the training required to make such interventions. These policies or procedures must meet the requirements of the state's public health and other laws regarding the provision and delegation of medical acts, as well as the requirements of IDEA, Sec. 504, and the ADA. And, most important, if a district has policies and procedures, it must tell all of its staff providing services about them -- not forgetting personnel such as paraprofessionals and bus drivers -- provide training on how to follow them, and then see that they are implemented.

Specifically, with regard to DNR orders, besides checking with legal counsel on their state's law, a policy, procedure, or guideline should be established on responding to DNR orders. And it must clearly advise employees that the decision to honor a DNR order is a district decision that must be followed by an individual employee.

If the district is in a state that requires a court order before a DNR order may be honored, or where the law is unclear, then unquestionably the district should not honor any DNR order absent being provided with a copy of an appropriate court order. A district would be well advised at least to monitor and very possibly participate in any such proceeding in an attempt to assure that the DNR order and the court's directives concerning the school are clear and can be implemented practically within the school setting. If not, an attempt should be made later, but before implementation, to have the court address various district concerns including possible liability.

If the district is located in a state that allows a third party, usually a family member, to make decisions concerning a DNR order without court intervention, it could basically "stonewall" the parent, refuse to honor the order, and take no other action. Or, it could advise the parent to obtain a court order. Given the previous discussion, these options would not be consistent with the law or with being a real advocate for the student. Upon receipt of the DNR order, it is suggested that the district take the following steps at a minimum:

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1. Gain assurance that the parent, guardian, or physician making the request has the authority to do so. For example, determine the relative rights of parents in a divorce situation and the extent of a guardian's authority. Obtaining a copy of the appropriate court order is often the best authority.

2. Ascertain whether any district staff has reason to believe the parent or guardian making the request lacks the authority to do so, has done so for ulterior motives (the parent may be frustrated from dealing with the problems the student presents), or the decision is just not in the student's best interest. Consultation with the district's legal counsel and the student's primary physician would also be appropriate at this point. Remember these activities will be only in preparation for a decision that arguably should be made by participants in an IEP meeting under IDEA or a Sec. 504 planning meeting.

If a district has concerns in one or more of these areas, it should advise the requesting party. If the concerns cannot be alleviated, it should then, consistent with its state's laws, consider initiating appropriate court action, as opposed to risking the various potential adverse consequences of taking no action as discussed above.

3. Assuming the district has no basis not to honor the request or order, it should be reviewed to determine whether it can be reasonably understood and implemented by employees. Is it in writing and sufficiently clear? Is its scope reasonably specific with regard to situations where CPR would be provided (*e.g.*, choking) and those where it would not? The district should not start implementing the order until such clarifications are provided. The array of foreseeable situations will obviously depend on the child's situation and, perhaps, on the physical facilities and configuration of the school building. All of these matters should be discussed and addressed beforehand with the parent and the child's physician. It may be particularly advisable to discuss the matter with the district's physician when a school nurse does not feel comfortable in providing advice.

4. Take care to identify and consider each step in the implementation process. Discuss with staff, parents and the child's physician exactly what steps will be taken in the event an arrest occurs. It is to be anticipated that district DNR policy will impose initial general responsibility on, for example, the classroom teacher or, where applicable, an aide assigned to the student subject to the DNR, and that the first responsibility will be to call directly to providers of emergency medical services. Thereafter, what will be done with the child between the time of the arrest and the time emergency response staff arrive on the scene? What type of comfort or reassurance will be provided to the child? Will the child be removed from other children or other children removed from the area? The parent or parent's physician should make and confirm arrangements between the district and the particular local emergency response service and hospital that will honor their DNR request.

5. Within the district, arrangements will need to be made to assure that all staff who might provide services to the student are alerted that a DNR order exists. Procedures should provide for at least one back-up person and ensure coordination of schedules so that misunderstandings cannot occur. Further, arrangements will need to be made to be sure that the properly trained staff person will be available to handle the situation. Finally, plans should be made to provide appropriate counseling and other educational programming for both staff and students about coming to terms with the experience of a student dying. Regarding this, and the topic in general, see an excellent series of articles entitled "Should a School Honor a Student's DNR Order?" 2 KENNEDY INST. OF ETHICS J. (1992) and the policy of the National Education Association on do not resuscitate orders adopted in June 1994.

6. Once agreed upon in a particular situation, all of the above arrangements should be set forth in a letter or some other type of document with all parties acknowledging in writing that they understand and agree that these are the procedures that will be followed in implementing the DNR order.

What Are Some Questions to Consider?

The policy considerations discussed above are a far cry from the practical problems that must be considered in implementing the policy. Once written policy regarding DNR orders has been developed and the information disseminated to all staff, specific written procedures regarding the identification, evaluation and planning required for any student, but particularly those with special health care needs, should be developed. Although general procedures may be developed on a district-wide basis, it will still be important to review these guidelines and adapt them to the specific schools. In other words, procedures will be highly specific to the individual child, school, transportation personnel and equipment, and parents. However, here are some general considerations.

<u>Are the parents involved in development of procedures?</u>

Involving parents should be considered even if it may not be required by law. Being most familiar with the student and health service needs, parents may be of substantial assistance in anticipating problems and advising how they might be resolved. Having been involved in development of procedures, parents should be more confident that their child's needs will be met satisfactorily. That should be reflected in far less friction and conflict in the event something

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doesn't work precisely as planned. The downside is that the school district could find itself in an embarrassing public dispute. However, it might be better to air this issue before, rather than after, a DNR order is implemented.

Should children without known medical needs be considered?

This article has been based on the assumption that a child's health needs are obvious -- indeed, so serious that implementation of a DNR order is a recognized possibility. However, any child may suddenly require resuscitation, remote as the possibility may be. In these situations, there will be no DNR order and, presumably, the basic requirements of state law will dictate the approach to be followed.

Are transportation personnel involved in developing procedures?

Since general procedures should provide for the entire school day, including periods of transportation, don't neglect this important area. While transportation personnel may not be consulted or involved in the initial policy development, they should be involved in developing the procedures to be followed for implementing the policy. A simple way would be to include a transportation person as part of the special education team assigned to develop the procedures.

Has an emergency situation been rehearsed?

It is ironic that while no one would be comfortable presenting even a first grade play without a number of rehearsals, that may be the last thing staff will address in preparing to implement DNR orders, a literal "life or death" situation. The best way to prepare for an emergency situation is to prepare for it in advance, including real life and real time rehearsals. This helps in at least two ways: Unanticipated problems may be revealed and personnel become familiar with what might be expected of them. No less important, if the emergency event is one that may cause curiosity or alarm on the part of other students, a fairly predictable reaction, it is highly desirable to include those students in at least some type of rehearsal.

How Should Other Students Be Handled?

One of the greatest objections to complying with a DNR order within the educational environment is projecting the impact of that course of action upon other students. To some degree, this is specious: Reacting to medical emergencies is part of commonly accepted school procedures. Handling a medical emergency involving a student subject to a DNR orders is another medical emergency.

But all medical emergencies are different and DNR orders are no exception. Probably the first question to be addressed is how to separate a student subject to a DNR order during an emergency from other students. Who shall be moved and to what location will depend largely on where the medical emergency occurs. Difficult as it may sound, all of the alternative environments in which a medically fragile student might be found during the school day should be considered. Each will pose special problems and limitations. In some circumstances, it may be possible to move other students; in others, it may be the medically fragile student who should be moved.

It is also critical to plan for counseling services, following implementation of a DNR order, for both students and faculty. Obviously, this will be a particularly sensitive subject, particularly for students in elementary schools. But it will be far easier and more effective to formulate procedures in advance of the need than to do so afterward.

Conclusion

If your school district has not yet had to deal with a DNR order, you have been fortunate. But don't waste the time that is available. DNR orders are not going to go away. The concerns and problems raised in their implementation will be with us for a long time. It is little less than irresponsible not to prepare for their implementation.

Given the emotional and value laden decisions involved in a DNR order and its implications -- as well as the differing and developing law on the subject in practically every state -- any district presented with a DNR order should address it promptly, consistent with the law in its state. Seek legal counsel immediately and try to assure that, to the extent that is appropriate, non-legal factors are considered and this is done in compliance with the state requirements governing DNR orders, and federal and state laws governing services to students with disabilities.

IDEA and Sec. 504 require a district and its staff to be child advocates. When a DNR order is presented, that advocacy is severely tested. Albeit more difficult than with other issues given the moral, political, and other factors that often arise, advocacy by educators must be consistent with the legal processes discussed above. In states where the family can presumptively make the decision, which is most states, just saying "no" is not an option.

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